MARKET CONDUCT DESK EXAMINATION REPORT
AS OF DECEMBER 31, 2007

TIME INSURANCE COMPANY
501 West Michigan Street
Milwaukee, WI 53203

NAIC Company Code 69477
NAIC Group Code 0019

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

TIME INSURANCE COMPANY

MARKET CONDUCT DESK EXAMINATION REPORT

as of

December 31, 2007

Examination Performed by

Kathleen M. Bergan, CIE

Independent Contract Examiner

February 27, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Morrison:

In accordance with §§ 10-1-203, 10-1-210 and 10-3-1106, C.R.S., a market conduct desk examination of certain health insurance business practices of Time Insurance Company has been conducted. The Company's policy forms, claims and underwriting records were examined by an independent contract examiner in South Bend, Indiana. This review covered the Company's Individual and Short Term Medical insurance policies.

The examination covered the period from January 1, 2007, to December 31, 2007.

A report of the desk examination of Time Insurance Company is herewith respectfully submitted.

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Kathleen M. Bergan, CIE

Independent Market Conduct Examiner

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COMPANY PROFILE

Time Insurance Company (hereinafter referred to as "the Company") first organized in LaCrosse, Wisconsin in 1892 as the LaCrosse Mutual Aid Association. The Company then moved to Milwaukee in 1900 and in 1905 changed the name to Time Indemnity. On February 11, 1910 the company incorporated and changed its name to Time Insurance Company and commenced business on March 6, 1910.

In April of 1969, Time Holdings, Inc. was formed to become the parent company of Time Insurance Company. During January of 1978, control of Time Holdings, Inc. was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. Effective April 1, 1998, Time Insurance Company changed its name to Fortis Insurance Company. Fortis Insurance Company's direct parent was Interfinancial, Inc., which in turn, was controlled by Fortis, Inc., in New York, New York. The ultimate controlling entities were Fortis AG, located in Belgium, and Fortis AMEV. Effective January 1, 1999, Fortis AG was renamed Fortis (B) and Fortis AMEV was renamed Fortis (NL) N.V. On September 27, 2001, Fortis (B) was replaced by Fortis SA/NV, a Belgian company, and Fortis (NL) N.V. was replaced by Fortis N.V., a Netherlands Company. The U.S. operations were known as Fortis, Inc., which was renamed Assurant, Inc. when it became a publicly traded company on the New York Stock Exchange through an Initial Public Offering (IPO) on February 5, 2004. Effective September 6, 2005, Fortis Insurance Company changed its name to Time Insurance Company.

The Company was issued a Certificate of Authority from the State of Colorado on September 24, 1956, and is licensed in all states, and the District of Columbia, except Hawaii and New York.

During the period under review, the Company's individual medical and short-term insurance products were principally marketed through a network of independent agents by Assurant Health. Products were also marketed to individuals through a variety of exclusive and non-exclusive national account arrangements and direct distribution channels including inbound call centers and online product access.

In addition, products were sold through State Farm Companies, in which their captive agents market Assurant Health's products with an exclusive national marketing agreement. Products are also offered directly to consumers through the Internet.

The Company's market share of all accident and health insurance business in Colorado in 2007 was 0.83% based on its total premium volume of 72,681,000.

PURPOSE AND SCOPE

This market conduct desk examination was performed by an independent contract examiner, who was assisted by Division of Insurance (Division) staff. This procedure is in accordance with Colorado insurance law § 10-1-204 C.R.S., which empowers the Commissioner to supplement the Division's resources to conduct market conduct examinations. The information in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of this desk examination was to determine the Company's compliance with Colorado insurance laws related to the following areas:

Company Operations and Management
Marketing and Sales
Policy Forms
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on the review of the above listed areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies that were discovered. These are discussed below.

For the period under examination, references included statutory citations and regulatory references related to individual and short-term medical insurance laws as they pertained to health carriers. Examination findings may result in administrative action by the Division. The examiner may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This examination report should not be construed to either endorse or discredit any health insurance carrier. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners and the Colorado Division of Insurance. In reviewing material for this report the examiner relied primarily on records and material maintained and/or submitted by the Company. The examination covered a twelve (12) month period of the Company's operations, from January 1, 2007, to December 31, 2007.

File sampling was based on a review of underwriting and claims files that were systematically selected by using ACL™ software from computer data files provided by the company. Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. As noted above, upon review of each file, any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding, the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each sample, the Company was provided a summary of the findings for that sample.

As noted, the examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. References to any practices, procedures, or files that manifested no improprieties were omitted.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims or ten percent (10%) for other samples was established to determine reportable exceptions. However, if an issue

appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the indicated tolerance levels, the results of any other samples with exception percentages within the indicated tolerance levels were also included. An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or system, a zero dollar ($0) tolerance level was applied in order to identify possible system errors.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance by the Division. Examination findings may result in administrative action by the Division.

EXAMINERS' METHODOLOGY

The examination consisted of a review of the Company's business practices to determine compliance with certain Colorado insurance laws. For this desk examination, special emphasis was given to the laws shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions - definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials - legislative declaration - definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration - repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 6-4-2	Standards for Safeguarding Customer Information

Company Operations/Management

The examination consisted of a review of Company management, implementation, and quality controls, record retention, marketing and timely cooperation with the examination process.

Contract Forms

A review was performed of the following contract forms, endorsements and riders:

Form Number	Form Name
TIME INSURANCE COMPANY	
INDIVIDUAL MEDICAL FORMS	
253.S01.CO	Save Right Traditional-HSA
25722AH	Policyholder and Account Information
13700AH	Correspondence letter
Rider 2844	Accident Medical Expense Rider
Rider 2847	Traditional Coverage Rider
100.001.CO	Medical Policy
Rider 2767	Policy Amendment Rider-Colorado
Rider 2461	Doctor's Office Copayment Rider
Rider 2610	Network Physician Hospital Coverage Rider
253.001-CO	Right Start-Traditional
Rider B321	Cancer Outpatient Benefit Rider
0778-CO	CoreMed Medical Policy
	MaxPlan Medical Policy
	OneDeductible PPO
	OneDeductible Traditional
Health Plan Description Forms	
192-CO	Medical Policy
225-CO	Medical Policy
Rider 2802-CO,B115	Mental Illness and Substance Abuse rider
Rider B119	Network Doctor/Hospital Coverage rider
0236-CO	Medical Policy
660-CO	Medical Policy
SHORT TERM MEDICAL	Individual Health Insurance Policy Major Medical Expense Coverage
136.001.CO (Revised 07-2005)	Short Term Medical Policy
2338	Summary of the Life and Health Insurance Protection Act and Notice concerning Coverage Limitations and Exclusions.

Underwriting

For the period under examination, systematically selected samples (using a random seed) of underwriting, including new business applications, declinations, rescissions, and files issued with exclusionary riders was taken as follows:

Underwriting Population to Sample Size
For Individual and Short Term Polices
January 1, 2007 through December 31, 2007

Review Lists for Individual Medical and Short Term Health Policies	Population	Sample Size	Percentage of Population Reviewed
Issued Policies	2,550	60	2.35%
Policies with Exclusionary Riders	464	60	12.9%
Declined Polices (Individual)	186	50	26%
Rescissions (Individual)	24	24	100%
Issued Policies (Short Term)	6,340	116	1.85%
Declined Polices (Short Term)	16	16	100%
Rescissions	17	17	100%

Underwriting files were reviewed to trace actual source documentation for each sample file.

Claims

The following shows the claim population to sample size for the period under review:

Claim Population to Sample Size
For Individual and Short Term Polices
January 1, 2007 through December 31, 2007

Review Lists for Individual Medical and Short Term Health Policies	Population	Sample Size	Percentage of Population Reviewed
Paid Claims over 90 days. (Individual Policies)	168,728	240	.14%
Denied Claims (Individual Policies)	17,685	116	.66%
Paid and denied Autism Claims (Individual Policies)	50	50	100%
Paid Mammogram Claims (Individual Policies)	3,539	115	3.25%
Denied Mammogram Claims (Individual Policies)	167	79	47%
Denied Claims (Short Term Policies)	2,251	115	5.2%
Denied Autism Claim (Short Term Policy)	1	1	100%
Paid and Denied Mammogram Claims (Short Term Policies)	39	39	100%

Samples were derived using ACL™ software and sampling recommendations found in the 2008 NAIC Examiners Handbook. The Company's data lists were stratified in order to sort data and classify claims according to specific categories for review. Random seeds were used in choosing sample size with ACL™ to derive sample numbers as recommended by the NAIC Examiners Handbook.

Utilization Review

The following table shows the population to sample size for the period under review:

Utilization Review Population to Sample Size
January 1, 2007 through December 31, 2007

Review List	Population	Sample Size	Percentage of Population Reviewed
Utilization Review	1,294	114	8.81%

Utilization Review files were examined for compliance for both approved and denied benefits as well as first and second level appeals of adverse determinations.

EXAMINATION REPORT SUMMARY

Company Operations and Management:

In the area of company operations and management one (1) compliance issue is addressed in this report :

Issue A1: Failure by the Company, in some cases, to maintain records required for Market Conduct purposes.

Marketing and Sales:

In the area of marketing and sales, two (2) compliance issues are addressed in this report.

Issue B1: Failure by the Company to clearly identify the actual insurer on marketing materials distributed for the sale of Company health products.

Issue B2: Failure by the Company to include a required disclosure regarding portability of prior coverage in its marketing and application materials for short-term medical policies.

Contract Forms

In the area of contract forms, three (3) compliance issues are addressed in this report:

Issue E1: Failure by the Company to follow the required rules and format for the Colorado Health Plan Description Forms.

Issue E2: Failure by the Company to allow benefits for covered services based on a licensed provider's status as a family member or employer of the insured.

Issue E3: Failure by the Company to reflect the correct description of coverage to be provided for prostate cancer screening in individual policies.

Claims

In the area of claims six (6) compliance issues are addressed in this report:

Issue J1: Failure by the Company, in some cases, to pay benefits for mammograms as mandated under Colorado insurance law.

Issue J2: Failure by the Company to allow up to thirty days for claimants to provide additional information before denying claims.

Issue J3: Failure by the Company, in some cases, to pay autism claims at mandatory benefit levels under Colorado insurance law.

Issue J4: Failure, by the Company, in some cases to accurately process claims.

Issue J5: Failure by the Company, in some cases, to accurately track the number of days required to adjudicate claims.

Issue J6: Failure by the Company to accurately display the actual name of the Company on claim information and the Explanation of Benefits.

Utilization Review

There were no areas of concern related to Utilization Review noted during the examination.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of any previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

TIME

INSURANCE COMPANY

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure by the Company, in some cases, to maintain records required for Market Conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of §10-1-109(1) C.R.S., states in part:

Section 4. Records Required For Market Conduct Purposes

A. Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to, company operations and management, policyholder services, *claim's practices*, rating, underwriting, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years.

Section 6. Claim Records

The claim records shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim records shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. [Emphases added.]

Denied Individual Policy Claims

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Denied Individual Medical Claims	17,685	116	8	7%

During the review of the sample of denied individual medical claims, it was noted that eight (8) files were missing copies of the original claim and/or there was no date stamp on the claim to document when the claim had been received.

Recommendation Number 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has implemented necessary changes and established procedures to ensure that all records required for Market Conduct purposes are maintained as required by Colorado insurance law.

MARKETING AND SALES

Issue B1: Failure by the Company to clearly identify the actual insurer on marketing materials distributed for the sale of Company health products.

Colorado Insurance Regulation 4-2-3, Advertisements of Accident and Sickness Insurance, promulgated under the authority of §§10-1-109 and 10-3-1110, C.R.S., states in part:

Section 15. Identity of Insurer

A. *The name of the actual insurer shall be stated in all of its advertisements*. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. *An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.* [Emphases added.]

A review was performed of a sample of the Company's advertising and marketing materials for the period under examination. Based on this review it appears the Company is not in compliance with Colorado insurance law in that some of its marketing materials identify the company offering the product as "ASSURANT Health" and not as Time Insurance Company. In some cases, information is provided in a footnote in small print at the bottom of the page that states that “Assurant Health” is a brand name for products underwritten and issued by Time Insurance Company and John Alden Insurance Company, but it does not disclose which of those two companies are actually underwriting and issuing the product. In addition, the Colorado Health Plan Description Forms also use the "ASSURANT Health" name at the top of the forms instead of correctly identifying the company as Time Insurance Company. This could result in an insured not knowing the true identity of the insurance company under which they are insured.

The following are those marketing materials which did not appear to be in compliance with Colorado Insurance law:

Individual Medical

Form 29233 (11/2007)
Form 29234-Rev. 11/2007
Form 29249 (Rev. 11/2007)
Form 29250 (Rev. 6/2007)
Form 29250 (Rev. 11/2007)
Form 29252 (Rev. 11/2007)
Form 29697 Rev. 11/2007)

Short Term Medical

Form 16180 (Rev. 8/2005
Form 22703 (Rev. 6/2007)
Form 24172 (Rev. 8/2005)
Form 24344 (Rev. 7/2006)
Form 26114 (Rev. 6/2007)
Form 28080 (Rev. 8/2005)
Form 28411-CO (Rev. 9/2007)
Form 28595 (Rev. 9/2007)

Form 28971 8/2005
Form 28986 (Rev. 5/2007)
Form 29026 (Rev. 3/2007)
Form 29565 1/2007
Form 29698 8/2007
Form 29698 12/2007

Recommendation Number 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-3. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable advertising and marketing materials to clearly identify the actual name of the insuring company as required by Colorado insurance law.

Issue B2: Failure by the Company to include a required disclosure regarding portability of prior coverage in its marketing and application materials for short-term medical policies.

Section 10-16-102, C.R.S., Definitions- states in part:

> (21)(b) *"Health benefit plan" does not include:* Accident only; credit; dental; vision; medicare supplement; benefits for long-term care, home health care, community-based care, or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, workers' compensation or similar insurance; or automobile medical payment insurance. The term also excludes specified disease, hospital confinement indemnity, or limited benefit health insurance if such types of coverage do not provide coordination of benefits and are provided under separate polices or certificates. Solely with respect to the provisions of section 10-16-118 (1) (b) concerning creditable coverage for individual policies, the term excludes *individual short-term limited duration health insurance policies issued after January 1, 1999.* This means such policies do not have to recognize creditable coverage. *For the purpose of this paragraph (b), "short-term limited duration health insurance policy" means a nonrenewable individual health benefit plan with a specified duration of not more than six months that meets the following requirements:*
>
> (II) *The short-term limited duration health insurance policy contains the following disclosure in ten-point or larger bold-faced type in all marketing materials, application forms, and policy forms: "This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months of the effective date of this policy will not be covered under this policy."* [Emphases added.]

It was noted during the review of the Company's marketing materials for its short-term medical policies, (including applications), that the Company did not include the above disclosure regarding lack of portability of prior health coverage as required under Colorado insurance law.

Therefore, a prospective insured may not be aware of the limitations of coverage as well as the lack of portability of prior health coverage if coverage is obtained under a short term medical policy.

Recommendation Number 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable advertising, marketing and application materials to reflect the required disclosures regarding short term medical policies, to ensure compliance with Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure by the Company to follow the required rules and format for the Colorado Health Plan Description Forms.

Colorado Insurance Regulation: 4-2-20, Concerning The Colorado Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S. states in part:

Section 2. Scope and Purpose

The purpose of this regulation is to establish and implement rules concerning the format for, elements of, and issuance of a Colorado Health Benefit Plan Description Form, pursuant to Section 10-16-108.5(11)(b), C.R.S. As required by law, the form is designed to facilitate comparison of different health plans by persons interested in purchasing or obtaining coverage under a health benefit plan. As also required by law, this regulation sets out procedures for carriers to make available a Colorado Health Benefit Plan Description Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer. This regulation is being changed in response to concerns from interested parties.

Section 3. Applicability

This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after July 1, 2007.

Section 4. Rules

A. Effective July 1, 2007, all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage shall make available to a producer or consumer through electronic means or hard copy, a completed copy of the Colorado Health Benefit Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer as one of the final choices from which the ultimate selection will be made, except as provided in Part B of Section 4 of this regulation.

B Carriers marketing or providing a Medicare supplemental plan will be deemed to have met the requirement of Part A of Section 4 of this regulation if, in lieu of the Colorado Health Benefit Plan Description Form, they make available for each such plan a Medicare supplement outline of coverage as prescribed in Colorado insurance regulation 4-3-1, 3 C.C.R. 702-4. Carriers shall make available the Medicare supplement Outline of Coverage pursuant to Part E of Section 4 below.

C. Carriers shall use the exact format found in Appendix A for the Colorado Health Benefit Plan Description Form, including all headings, notes, row numbers, and footnotes. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a landscape rather than a portrait page layout format, but carriers shall follow the exact requirements and use only the choices set forth in the directions found in Appendix B of this regulation. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to Section 10-3-1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

It appears that the Company is not in compliance with Colorado insurance law in that its Colorado Health Benefit Plan Description Forms for all short term and individual medical plans with revision dates of 8/2007 and 11/2007 were not created in the prescribed format.

Some of the areas noted that were not in compliance are:

- Coinsurance information is listed at the beginning of the form instead of correctly including it as part of the Out of Pocket Maximum.
- "MEDICAL OFFICE VISITS" did not include a separate entry for Primary Care Providers and Specialists.
- The heading for Outpatient / Ambulatory Surgery did not include dollar amounts or reference to maximums and out-of-pocket maximums.
- Laboratory and X-Ray were listed together instead of listing under "Diagnostics", with separate entries for Laboratory & X-ray, MRI, nuclear medicine, and other high-tech services.
- Biologically Based Mental Illness was either listed as excluded or referenced as the same coverage as "other mental illness".
- Dental Care should include the mandatory provision for hospitalization and general anesthesia for dental procedures for dependent children (§ 10-16-104 (12), C.R.S.).

In addition, the entire numbering system and format on this form is incorrect, and in some cases, the Company excluded all of Part D as required by under Colorado Insurance Regulation 4-2-20.

Recommendation Number 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-20. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable Health Benefit Plan Description Forms to provide all required information in the required format to ensure compliance with Colorado insurance law.

Issue E2: Failure by the Company to allow benefits for covered services based on a licensed provider's status as a family member or employer of the insured.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (7) Reimbursement of providers.
>
> (a) Sickness and accident insurance.
>
> (I)(A) Not withstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of Part 2 of this article or a prepaid dental care plan subject to the provisions of Part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its short-term medical certificate excludes coverage for services rendered by, or supplies purchased from a member of the insured's immediate family or an employer.

The Company's short-term medical certificate includes the following exclusion on page 19:

> "13. Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer."

The policy may not exclude reimbursement for covered services performed by a licensed provider based on the status of the provider as a family member or employer of an insured if the services are within the provider's scope of practice and the provider normally charges for the services.

Form:

136.006.CO (No Date)

Recommendation Number 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable forms to provide coverage for services provided by a licensed provider regardless of the provider's status as a family member or employer of the insured, as required by Colorado insurance law. The Company should also be required to conduct a self-audit from January 2007 to the present, and adjust any claims that may have been denied due to a provider being a member of the insured's family or an employer of the insured.

Issue E3: Failure by the Company to reflect the correct description of coverage to be provided for prostate cancer screening in individual policies.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(10) Prostate cancer screening.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. This coverage shall be provided according to the following guidelines:

(I) The screening shall be performed by a qualified medical professional, including without limitation a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant.

(II) The screening shall consist, at a minimum, of the following tests:

(A) A prostate-specific antigen ("PSA") blood test;

(B) Digital rectal examination.

(III) At least one screening per year shall be covered for any man fifty years of age or older.

(IV) *At least one screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer as determined by the man's physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article.*

(b) The requirements of this subsection (10) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 1996, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 1996.

(c) For purposes of this subsection (10), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as defined in section 10-18-101 (3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.

(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (10) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

It appears that the Company is not in compliance with Colorado insurance law in that its individual polices did not include an accurate description of the benefits required for prostate cancer screening.

The Company policy language under the "Wellness Services" portion under the policy for prostate cancer screening shows:

> "Screenings include a digital rectal examination and a prostate-specific antigen test for a covered male age 50 and older and a covered male *age 40-45* at high risk for prostate cancer as determined by a physician."

This language is more restrictive and creates a gap for insureds with a family history of prostate cancer between the ages of forty five (45) and fifty (50) years of age. Colorado insurance law requires high risk insureds be permitted a prostate exam as frequently as once per year between the ages of forty (40) and fifty (50) years of age.

Applicable individual policies that have the restrictive language are:

Form:

Right Start (Form 253)-PPO	(No Date)
Coremed	(No Date)
Save Right PPO	(No Date)
Save Right Traditional	(No Date)

Recommendation Number 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended all applicable form language regarding prostate cancer screening to ensure compliance with Colorado insurance law. The Company should also be required to conduct a self-audit from January 1, 2007 to the present to identify and pay any claims that may have been incorrectly denied as a result of the Company's incorrect language.

CLAIMS

Issue J1: Failure by the Company, in some cases, to pay benefits for mammograms as mandated under Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(4) Low-dose mammography.

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. *Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles.* Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. If an insured person who is eligible for a routine mammography screening benefit pursuant to subparagraphs (I), (II), and (III) of this paragraph (a), has not utilized such benefit during a calendar year or a contract year, then such provisions shall apply to one diagnostic screening for such year. If more than one diagnostic screening is provided for such person in a given calendar year or contract year, the other diagnostic service benefit provisions in the policy or contract shall apply with respect to such additional screenings. This mandated mammography coverage shall be provided according to the following guidelines:

(I) Provision of a single baseline mammogram for women thirty-five years of age and under forty years of age;

(II) Screening not less than once every two calendar years or contract years for women forty years of age and under fifty years of age, as specified in the insured's policy or contract, but at least once each such calendar year or contract year for a woman with risk factors to breast cancer as determined by her physician for an entity subject to part 2 or 3 of this

> article, or as determined by a participating physician for an entity subject to part 4 of this article; [Emphases added.]

Colorado Insurance Regulation 4-2-13, Mammography Minimum Benefit Levels, promulgated under the authority of 10-1-109, C.R.S., states in part:

> II. BASIS AND PURPOSE
>
> The purpose of this regulation is to provide a method for adjusting the minimum mammography benefit which reflects increases and decreases in the consumer price index, as provided in §10-16-104(4)(a), C.R.S.
>
> III. RULE
>
> *As of September 1, 1995, the minimum mammography benefit will be $65.37. Hereafter, on September 1 of each year, every individual and group sickness and accident insurer, non-profit hospital, health service corporation and health maintenance organization subject to §10-16-104(4)(a) and 10-3-903(2)(h) C.R.S. shall annually update its mammography benefit to reflect the most recent annual national Consumer Price Index - Urban (CPI-U) published by the U.S. Bureau of Labor and Statistics.* This may be done by either revising the policy forms or evidence of coverage, processing claims at the new benefit level or both. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that in some instances, claims for this mandatory benefit were incorrectly denied.

In addition, it was noted during the review of paid claims that in some instances, the Company incorrectly applied the charges to the policy deductible, or failed to pay the mandatory amount of $88.91 for claims incurred from January 1, - August 31, 2007, and $92.73 for claims incurred from September 1, - December 31, 2007. These mandatory minimum payment amounts were based on changes to the national CPI-U as published by the Division for each year.

The following chart illustrates the significance of error versus that population and samples examined:

Denied and Paid Mammography Claims
January 1, 2007 through December 31, 2007

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Denied Mammography Claims	167	79	15	19%
Paid Mammography Claims	3,539	115	12	10%

Recommendation Number 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-13. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its claim procedures and provided additional training to its claims staff to ensure that correct benefits are paid for mammography claims in order to ensure compliance with Colorado insurance law.

The Company should also be required to conduct a self-audit from January 1, 2007 to the present, to identify and pay the appropriate benefits for any mammography claims that were denied or adjudicated incorrectly.

Issue J2: Failure by the Company to allow up to thirty days for claimants to provide additional information before denying claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphases added.]

During the review of denied claims (including mammography claims), it was noted that claims that were received directly from providers who were contracted with the Sloans Lake provider network and had not been repriced under the contract with Sloans Lake, were immediately denied. A copy of the Explanation of Benefits (EOB) sent to both the provider and insured stated that the claim had been denied due to the failure of the provider to send the claim to Sloans Lake for repricing. It appears the Company is not in compliance with Colorado insurance law since these claims were immediately denied instead of requesting repricing information, and without waiting the required thirty (30) calendar days for the additional information to be submitted. Colorado's prompt claim payment law allows a Company to deny claims needing additional information only after notifying the appropriate individual of the information needed and allowing up to thirty (30) calendar days from the date the notice is sent for the information to be received.

The following chart illustrates the significance of error versus the population and sample examined:

Denied Claims
From
January 1, 2007 through December 31, 2007

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Denied Mammogram Claims	167	79	5	6.3%
Denied Medical Claims	17,685	116	34	29.3%

Recommendation Number 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended its claims practices regarding claim denials to ensure compliance with Colorado insurance law. The Company should also be required to conduct a self-audit from January 1, 2007 to the present to identify and correct any claims that were inappropriately denied.

Issue J3: Failure by the Company, in some cases, to pay autism claims at mandatory benefit levels under Colorado insurance law.

Section 10-3-1104, C.R.S. Unfair methods of competition and unfair or deceptive acts or practices prohibited states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

Section 10-16-104.5., C.R.S., Autism - treatment - not mental illness states in part:

> (1) *Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article* and any individual or group service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article *which provide coverage for autism shall provide such coverage in the same manner as for any other accident or sickness, other than mental illness, otherwise covered under such policy.* [Emphasis added.]

The examiner reviewed the entire population of fifty (50) autism claims received during the period under examination. It appears that the Company is not in compliance with Colorado insurance law in that on three (3) of the fifty (50) autism claims, the Company incorrectly applied the mental health benefits instead of considering under the medical coverage which has higher benefit levels.

The following illustrates the significance of error versus the population and sample examined:

Autism Claims
January 1, 2007 through December 31, 2007

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Autism Claims	50	50	3	6%

Recommendation Number 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-104.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended its claims practices regarding autism claims to ensure compliance with Colorado insurance law. The Company should also be required to conduct a self-audit from January 1, 2007 to the present to identify and correct any Autism claims that were incorrectly processed under mental health benefits.

Issue J4: Failure, by the Company, in some cases to accurately process claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

It appears that the Company is not in compliance with Colorado insurance law in that nine (9) processing errors were noted during the review of short term medical claims from the information provided by the Company. The following is a summary of the errors pertaining to these nine (9) claims:

- Six (6) claims for professional fees related to laboratory services were denied on the basis that the professional services were not medically necessary and therefore not covered. However, since these claims were provided by contracted providers, the question of medical necessity should have been addressed between the carrier and the provider, and the insured should not be held responsible for any non-covered charges.

- Two (2) claims involved situations in which the company needed additional information in order to determine its liability. However, it appears that both claims were denied instead of requesting the needed information and waiting the required time for the information to be submitted.

- One (1) claim involved charges for an assistant surgeon that was denied on the basis that an assistant surgeon was not medically necessary. However, as with the claims for the professional fees for laboratory services, the charges were submitted by a contracted provider. Therefore, the issue of medical necessity should have been addressed directly with the provider without holding the insured responsible for any non-covered charges.

The following illustrates the incidence of error in processing short term claims:

Denied Short Term Medical Claims
January 1, 2007 through December 31, 2007

Review Lists	Population	Sample Size	Number of Exceptions	Percentage to Sample
Denied Short Term claims	2,251	115	9	7.8%

Recommendation Number 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended its claim processing procedures to ensure compliance with Colorado insurance law. The Company should also be required to conduct a self-audit from January 1, 2007 to the present to identify and correct any claims that were inappropriately denied.

Issue J5: Failure by the Company, in some cases, to accurately track the number of days required to adjudicate claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(2.7)(a) A policyholder, insured, or provider may submit a claim:

(I) By United States mail, first class, or by overnight delivery service;

(II) Electronically;

(III) *By facsimile (fax)*; or

(IV) By hand delivery.

(b)(II) If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the carrier or the carrier's clearinghouse. The carrier or carrier's clearinghouse shall provide a confirmation within one business day after submission by a provider.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means. [Emphases added.]

During the review of both the paid and denied claims samples, it was noted that the received date of the claim may not be the actual date received by the Company for processing and payment. The Company's current procedures for electronic claim submission (EDI) process are as follows. Although this process was created in November 2008, it is similar to the process that was in place during 2007.

"Electronic Claim Submission (EDI) Process
Created 11/10/08

EDI claims are received electronically from Emdeon, CareVu, Midlands Choice and Medical Mutual of Ohio (MMO). Each of these vendors transmits claims to Assurant on a daily basis.

Claims that are received from these vendors are entered into the ACES/BEST system with a received date equal to the date that the vendor produced the file for Assurant. For example, claims loaded into ACES/BEST on 11/7 could have a received date of 11/6, if the vendor extracted Assurant claims on the 6th.

Obtaining the date the vendor received the claim is difficult for a number of reasons:

1. The ANSI X12 standard does not have a field for "received date".
2. A claim may pass through 1 or more clearinghouses before reaching its final destination. For example, Doctor X could have a relationship with Clearinghouse #1. Because Assurant does not have a relationship with Clearinghouse #1, Clearinghouse #1 forwards the claim to Emdeon. Emdeon in turn would send the claim to Assurant. This has the potential to add additional days to the timeframe from when the provider submits the claim to their clearinghouse to when Assurant actually receives the claim.

> Assurant also has a relationship with Emdeon Business Services to convert paper claims into an electronic format. As Emdeon receives claims from the Postal Service, they scan them. As a part of the scanning process, a control number is sprayed onto the paper and captured on the image. This control number contains the received date in a julian format. In addition, the date that Emdeon received the paper claim is passed to Assurant in the electronic record. These claims are then entered into the ACES/BEST system with the corresponding received date.
>
> Many of our PPO network agreements require that the provider submit the claim to the network to be priced prior to Assurant receiving the claim. Based on our contract with Sloans Lake, the network is required to make their best effort to turn around repriced claims within 3 business days of receipt. Therefore, we built our processes around this time frame to incorporate the 3 days into our process for calculating the received date. Upon receipt of a claim, an additional 3 days is added to the date the claim is received in house, to account for the 3 days used for the network repricing."

From the review of paid and denied claims as well as the Company process in receiving claims, it was noted that the Company is unable to determine and accurately track the actual submission date and determine the number of days to adjudicate claims. This includes claims from Sloans Lake and other repricing vendors used by the Company.

Recommendation Number 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has amended its claim procedures to ensure the correct received date is recorded on all claims as required by Colorado insurance law. The Company should also be required to conduct a self-audit from January 1, 2007 to the present to identify and correct any interest and/or penalties that may be due on claims that were not adjudicated within the required time periods based on the correct received date.

Issue J6: Failure by the Company to accurately display the actual name of the Company on claim information and the Explanation of Benefits.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (I) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

During the review of claims it was noted that the Company uses "Assurant Health" on all it's EOB's and other claim correspondence, instead of Time Insurance Company. This is misleading and could lead to confusion for the insured who may not be aware that "Assurant Health" is the administrator of their plan, and that Time Insurance Company is the Company that actually underwrites the coverage.

Recommendation Number 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has corrected its procedures to ensure that the actual company name that underwrites the benefits is reflected on all claim correspondence to ensure compliance with Colorado insurance law.

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Independent Market Conduct Examiner
Kathleen M. Bergan, CIE
Participated in this examination and in the preparation of this report